

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-51-043929

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 393 Primary Registration District No. 1002 Registrar's No. 60210

FILED DEC 22 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>CLAY</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>CLAY</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> | | Length of stay in 1b <u>15 YRS</u> | | c. CITY OR TOWN <u>KANSAS CITY</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5915 E 50TH ST</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>5915 E 50TH ST.</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>ROY</u> Middle <u>FULTON</u> Last <u>ANDERSON</u> | | | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>10</u> Year <u>1961</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>9-18-1895</u> | 9. AGE (last birthday) <u>66</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER CORN PRODUCTS Co</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>CLINTON Co, MO</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | |
| 13a. FATHER'S NAME <u>HENRY P. ANDERSON</u> | | | 13b. MOTHER'S MAIDEN NAME <u>CYNTHIA MILLER</u> | | | 14. NAME OF HUSBAND OR WIFE <u>W.H. ANDERSON LATHROP, MD</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WWI</u> | | | | 17. INFORMANT <u>W.H. ANDERSON LATHROP, MD</u> Address _____ | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis (probable cause)</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>500</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | Month, Day, Year _____ | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | COUNTY | STATE |
| 21. I attended the deceased from _____, to _____, and last saw her/him alive on _____. Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>D. State M.D. Cronan</u> | | | | 22b. ADDRESS <u>North Kansas City Mo.</u> | | 22c. DATE SIGNED <u>12/10/61</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>12-11-1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>LATHROP CEM</u> | | 23d. LOCATION (City, town, or county) <u>LATHROP, MO</u> | | (State) | |
| 24. FUNERAL DIRECTOR <u>Bailey Funeral Home</u> | | | ADDRESS <u>LATHROP, MO</u> | | 25. DATE RECD. BY LOCAL REG. <u>12-11-61</u> | 26. REGISTRAR'S SIGNATURE <u>Ruth Long</u> | |

MAR 30 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Glen H. Hill

Licensed Embalmer No. 4586

P. O. Address K.C. 18, Mo

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.

If this body is not embalmed, fact should be so stated above.